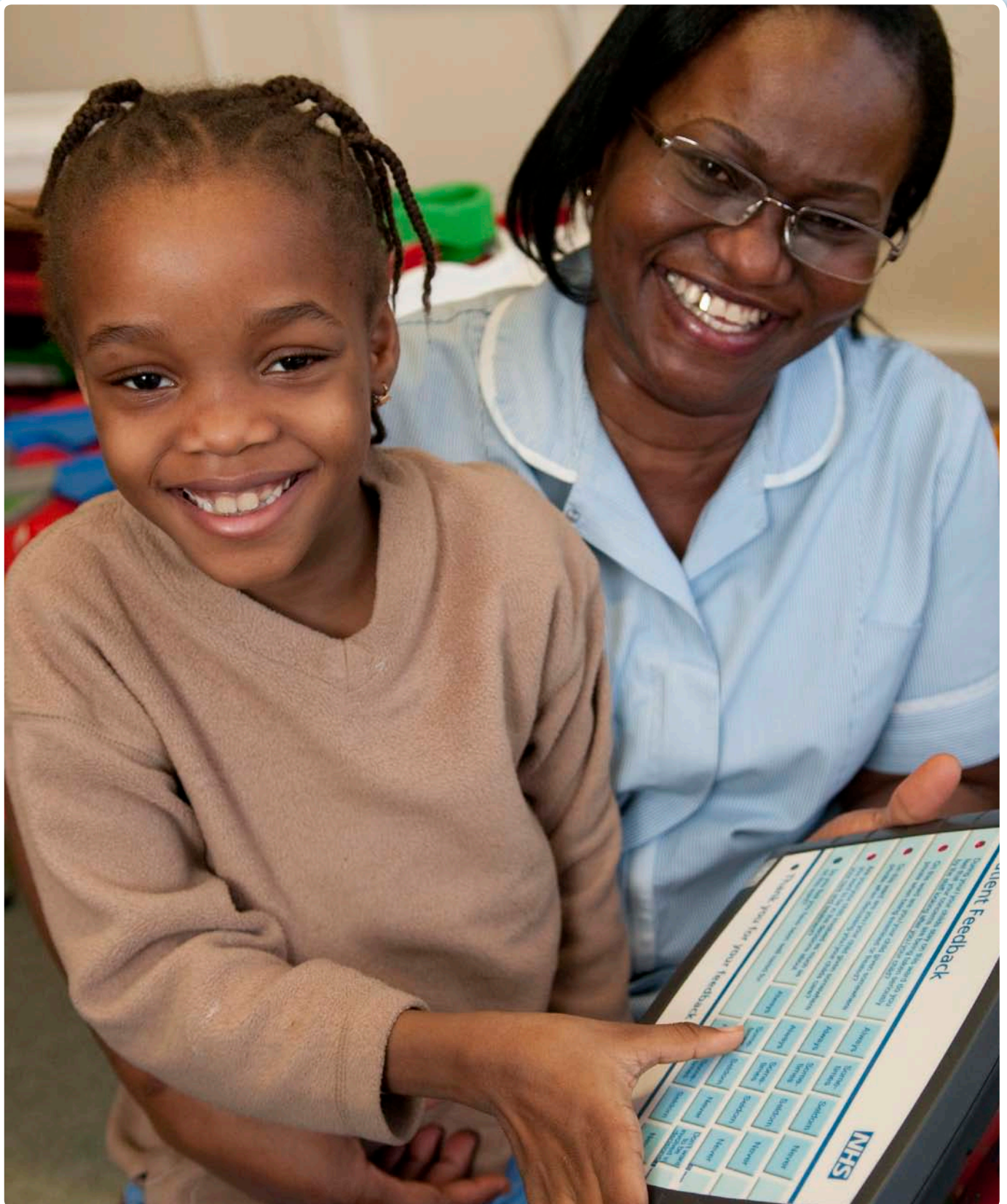


# Quality Account

2009/10



## Translation

If you would like this report translated, please call the communications team on 020 8266 6132, or email [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

### Arabic

إذا كنت تريد ترجمة هذا التقرير، فعليك الاتصال بفريق الاتصالات على 020 8266 6132، أو إرسال إيميل على [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

### Bengali

আপনি যদি এই রিপোর্টটিকে আপনার ভাষায় অনুবাদ করাতে চান, তবে অনুগ্রহ করে 020 8266 6132 নম্বরে কমিউনিকেশনস টিমকে ফোন করুন অথবা [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk) এই ঠিকানায় ইমেইল করুন।

### Chinese

如果你希望這份報告，翻譯成爲中文來閱讀，請你致電我們的傳播小組。電話：020 8266 6132 或電郵到：[communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

### French

Si vous souhaitez obtenir une traduction de ce rapport, appelez l'Equipe chargée de la communication (ou Communications Team) au 020 8266 6132 ou envoyez un mél à l'adresse suivante : [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

### Gujarati

આપણી જો આ રિપોર્ટટિકે આપણા ભાષા અનુવાદ કરાતે ચાન, તો અનુગ્રહ કરે 020 8266 6132 નંબરે કમિયુનિકેશનસ ટીમકે ફોન કરૂન અથવા [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk) આઈ ઠીકાનાય ઇમેઈલ કરૂન।

### Polish

Aby otrzymać tłumaczenie tego raportu, proszę o kontakt z zespołem ds. komunikacji pod numerem 020 8266 6132 lub przez email: [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

### Somali

Haddii aad dooni in warbixinta lagu turjumo, fadlan ka ax Communications Team 020 8266 6132 ama email u dir [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

### Spanish

Si desea leer una traducción de este informe por favor llame al 020 8266 6132 o solicítelo enviando un mensaje a: [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

# Quality Account Contents

## **Priorities for improvement** 2

Developing the Quality Account  
Review of services  
Participation in clinical audits  
Research  
CQUINs  
What others say about St George's  
Data Quality  
Information governance  
Clinical coding

## **Improving patient safety** 7

Prevention of falls  
Infection control  
Incident reporting  
Executive walkabouts  
Safeguarding children

## **Increasing clinical effectiveness** 12

Mortality (death rates)  
Benchmarking  
Clinical audits  
Productive ward – releasing time to care

## **Improving the patient experience** 17

Same sex accommodation  
Patient Experience Trackers  
Establishing a better hospital environment  
Nutrition and hydration  
Managing complaints  
Interpreting services  
Improving care for patients with learning disabilities  
Inpatient survey results 2009  
Developing our workforce

## **Acknowledgements and contacts** 23

## **Appendices** 24

Appendix A 24  
Appendix B 27  
Appendix by CQUIN summary 2010/11

# Executive summary

**The announcement by Dr Foster, the healthcare intelligence agency, that St George's Healthcare NHS Trust, was its 2009 'Large Trust of the Year' really does demonstrate our commitment to high quality, patient-centred care, and the progress the trust continues to make in raising clinical quality.**

Dr Foster's guide focused on patient safety and St George's was recognised as being one of the five leading Trusts in England in this area, as well as for providing quality services for patients. These findings are underpinned by some powerful indicators of quality, such as our significantly lower than expected mortality rates.

It's no coincidence that we've been officially recognised for outstanding services – quality is at the heart of everything we do at the trust. Our staff have an unwavering dedication to maintaining high standards and exploring how we can work even better. Just look at the tangible benefits delivered as a result of the productive ward initiative, an ongoing programme of better organisation and efficiency on our wards. Our ward staff now spend over 20 per cent more time directly caring for patients, and it's all down to their hard work and commitment, and a resolute focus on doing things better.

Infection control rates within the trust are low. In fact, we've been one of the top performing teaching hospitals in the country for several years. We have very robust systems in place to ensure our patients are safe from infection, and everyone on site is encouraged to maintain high standards of hygiene when visiting our wards and patient areas.

We strive to provide tailored care packages to individual patients at St George's, whatever their circumstances. The appointment of a consultant nurse in learning disabilities is a fine demonstration of this pledge – the role is the first of its kind in the country and is helping the trust break new ground in looking after some of the most vulnerable members of our community. The trust's new 'patient passport', an award-winning scheme, is also making a difference by helping patients with learning disabilities to communicate their needs more clearly to staff.

All these items are covered in more detail in this, our first ever quality account, which examines all information relating to quality at St George's, allowing the trust Board, and the public, to identify where the trust performs well in relation to quality and where improvement is needed. Statistics show that St George's is a safe hospital, but we must measure accurately what we do, continually review how we perform and use that information in the right way in order to drive further improvements and benefits for patients.

This quality account helps make us more transparent as an organisation, and allows our patients, staff, local commissioners and other NHS bodies, as well as our local community, understand how we perform and where we continue from the continual review of our services to deliver better, safer healthcare.

It's essential that we recognise how important our local community is and we are looking to galvanise our ties locally by integrating with community services in Wandsworth. St George's submitted a preferred bid to take on these services and looking ahead we hope to integrate these into the fabric of the trust during 2010/11.

Our bid to become a Foundation Trust next year should further enhance our relationship with the local community, giving us more financial independence, and allowing us to invest in the services our local patients need. Looking forward in this way we have also set up a project to review the Trust's core values and objectives which will inform the way we intend to approach healthcare up until 2015.

Of course, this quality account can't possibly cover absolutely everything – staff throughout the trust continually work to improve care and outcomes for their patients, and there are endless examples of excellent individual practice. This report however does provide a flavour of the quality experience at the trust, which I hope inspires confidence in our services, while also identifying areas where measurable improvements can be delivered.



David Astley  
Chief Executive



# Priorities for improvement

## Our philosophy

'We will work tirelessly to give outstanding care to all of our patients. We will enhance our position as a leading specialist teaching hospital at the forefront of health care, with excellence in service, teaching and research'.

The mission statement of St George's outlines a robust commitment to patients and gives a clear vision of the future. To achieve this vision, the Trust agreed that it must have a clear set of values to guide its work, so seven values were developed which underpin all the care we provide.

## Our seven values...

- Treat all people with respect and dignity
- Deliver care in partnership with others
- Continually strive for clinical excellence
- Ensure probity and transparency in spending public money
- Be an exemplary employer
- Be committed to excellence in education, training and research
- Be open and honest with each other and those outside the organisation

Six strategic aims are also in place, which are helping to guide the Trust in goal-setting and, underpinned by our seven values, are leading St George's into the future.

## Our six strategic aims...

- To be the provider of choice
- To strengthen and expand our flagship specialist services and network hubs
- To develop an academic health and social care network in SW London
- To ensure financial sustainability
- To be an exemplary employer with career and development opportunities which attracts, motivates and retains employee talent
- To provide an excellent physical environment fit for the delivery of modern healthcare

A series of objectives have also been developed, designed to deliver each of these six aims, centring on increasing efficiency, raising productivity levels and improving the care and experience of patients.

## Things to do...

Review our mission statement, values and strategic aims to deliver a new framework to guide the trust through to 2015

## Developing the Quality Account

In November 2009, a group was established to guide the production of the Quality Account. It was recognised that while there were a number of quality improvement initiatives underway at St George's, linked to our strategic objectives, it was important to seek the views of stakeholders to help decide where we should focus our final report. We will be extending our consultation on the quality account next year to ensure more comprehensive feedback is gleaned from local stakeholders on the areas for examination for 2010/11.

In February 2010 patient groups and stakeholders were contacted and provided with an explanation of the rationale for the quality account and the outline of its contents. Feedback was invited and taken into account when planning the final document. An equality impact assessment was undertaken which is available on request (email [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)).

This consultation was hugely important in informing the basis of the quality account, which demonstrates our approach and commitment to improving quality at St George's by focusing on key activity within three themes:

- **Patient Safety:** Including incident reporting, falls prevention, infection control
- **Clinical Effectiveness:** Including the Productive Ward initiative, mortality rates, clinical audits
- **Patient Experience:** Including patient complaints, nutrition and hydration, initiatives for people with learning disabilities

Focusing on these areas gives us the opportunity to make tangible, measurable improvements and really improve our services in a way that delivers better and safer healthcare for patients at St George's.

## Review of services

We recognise the need to adopt a more systematic approach to reviewing quality of care across each of our services. It is fully intended that St George's will approve a quality strategy, incorporating the three dimensions of patient safety, clinical effectiveness and patient experience during 2010. A rolling plan will be established to review services across these three parameters, benchmarking the trust against appropriate national or international comparators.

### Things to do...

Develop a quality strategy to introduce measures and metrics that benchmark on performance against 'best in class'

## Participation in clinical audits

Clinical audits are designed to improve patient outcomes across a wide range of medical, surgical and mental health conditions. Their purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care.

Confidential enquiries are special studies that seek to improve health and health care by collecting evidence on aspects of care, identifying any shortfalls, and disseminating recommendations based on their findings.

During 2009/10, 33 national clinical audits and seven national confidential enquiries covered NHS services provided at St George's. During that period we participated in 88 per cent national clinical audits and 100% of those national confidential enquiries that the Trust was eligible to participate in (see TABLE 1, Appendix B).

The reports of 0 national clinical audits were reviewed by the provider in 2009/10, at Board Level. However, reports generated from the national audits that the Trust have participated in are discussed at various service and governance meetings and a summary of the process for each of the reports is given below. The patient safety committee is chaired by the chief executive (see TABLE 2.5. Appendix B).

The reports of 0 local clinical audits were reviewed by St George's Healthcare NHS Trust in 2009/10, at Board Level. However, local audit projects are reviewed at various service and governance meetings. Those that are supported by the clinical audit team are summarised for and reviewed by the Clinical Effectiveness and Audit Committee. Each year an annual report of all audit activity, including a list of all registered local audits and national audits is summarised for and reviewed by the Patient Safety Committee. (See TABLE 6, appendix B)

Following publication of 'Clinical Audit: A simple guide for NHS Boards and partners by Healthcare Quality Improvement Partnership' a meeting has been arranged to examine and improve the link between the Board and clinical audit.

### Things to do...

Ensure clinical audit activity is properly considered at Board level

## Research

We make a firm commitment to research at St George's, as a key driver for improving quality of care and the patient experience, and there were 1592 NHS patients who took part in research at the Trust during 2009/10\*.

The trust was involved in conducting over 500 clinical research studies in this period. Together with our academic partner, St George's, University of London (SGUL) we also established a dedicated clinical research facility, which has significantly enhanced our capacity to carry out further studies and increased patient involvement in a safe, fully-equipped and resourced environment.

In addition, and again in partnership with SGUL the trust also hosts the South East Stroke Research Network (SESRN). The SESRN has been active over the last year in developing and expanding a local network portfolio and at the end of 2009/10 is recruiting to 22 different studies with a further ten unique studies in set up. It is the second highest recruiting stroke network in the UK for the second year running and remains the highest recruiting centre to stroke portfolio trials throughout the whole of the UK to date. Over a measured period in 2009, we successfully recruited 39.4% of all patients to National Institute for Healthcare Research portfolio studies and in the last three years (2007-2010), more than 450 corresponding author publications in scientific peer-reviewed journals have resulted from our research.

This increasing level of participation and engagement in clinical research demonstrates our solid commitment to making a significant contribution to wider health improvement as well as improving the quality of care we offer patients.

\* Patients receiving NHS services provided or sub-contracted by St George's during 2009/10 that were recruited during that period to participate in research approved by a research ethics committee (National Institute for Health Research portfolio studies only).

## CQUINs

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of the hospital's income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All (2008), of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion throughout the country.

A proportion of St George's income in 2009/10 was conditional on achieving quality improvement and innovation goals as agreed between the Trust and Primary Care Trusts, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2009/10 and for the following 12 month period are listed in Appendix C of this quality account. The outcomes of these CQUINs will be reported on in the 2010/11 quality account.

## What others say about St George's

The Care Quality Commission (CQC) is the independent health and social care regulator for England and as of April 2010 all NHS hospitals by law have to be registered with the CQC in order to provide their services.

Registration is now the new method of regulating health and social care. This means that NHS hospitals have a responsibility to ensure that the treatment, care and support they provide to patients meets the CQC's 28 essential standards of safety and quality.

The CQC continuously monitors NHS hospitals by checking on the quality of the care people experience, rather than on systems and processes, to ensure that essential standards of safety and quality continue to be met.

St George's is registered with the CQC with no conditions, which means that we successfully meet the requirements of safety and quality for each of the CQC's 28 standards.

The CQC has not taken any enforcement action against St George's in 2009/10. Looking ahead, the Trust will be assessed as part of the CQC's overview programme of reviews/studies which are due to take place in mid April 2010.

This quality account was shared with a number of local stakeholder organisations, including NHS Wandsworth, Sutton and Merton links, Richmond and Twickenham PCT, Wandsworth Overview and Scrutiny Committee (WOSC). NHS Wandsworth and WOSC provided feedback on the report. The content of this report was also assured by NHS London, the strategic health authority, in terms of its adherence to the guidance.

\*To read what some of the stakeholders have said about this report, see Appendix A





## Data quality

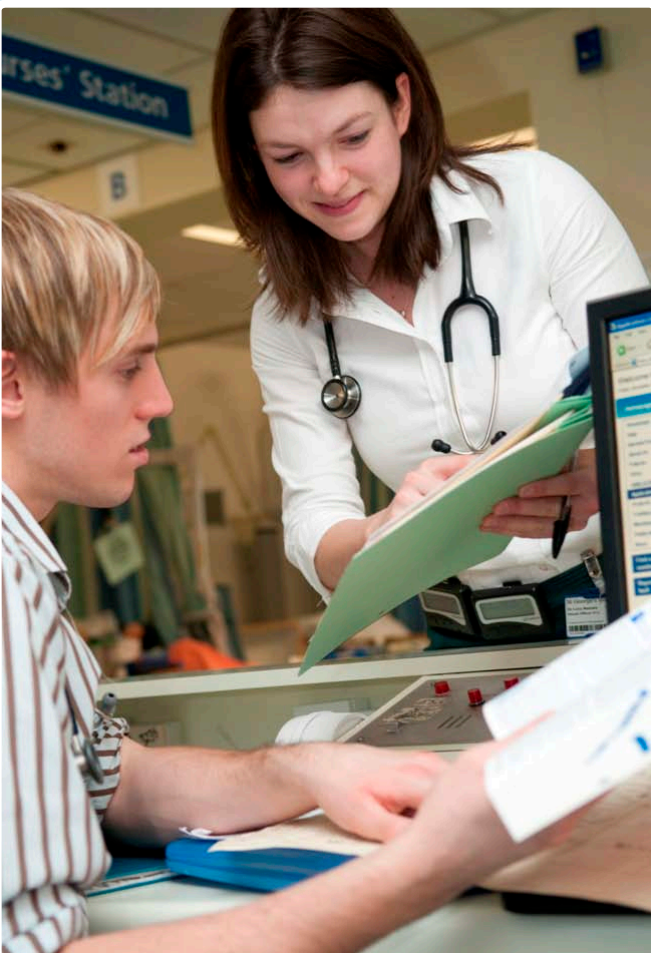
St George's submitted records during 2009/10 to the secondary uses service for inclusion in the hospital episode statistics (HES) which are included in their latest published data. HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. The body provides a data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.

### Things to do...

Ensure greater clinical involvement in validating information derived from clinical activity and complete a full review of corporate information assurance

The percentage of records in the published data which included the patient's valid NHS number was 94.9 per cent for admitted patient care, 97.1 per cent for outpatient care and 68.6 per cent for A&E care.

The percentage of records in the published which included the patient's valid General Medical Practice Code was 100 per cent for admitted care, 100 per cent for outpatient care and 89.7 per cent for A&E care.



## Information governance

Information Governance (IG) is the term used to describe the standards and processes for ensuring that St George's complies with the law, regulation and best practice in handling and dealing with information. IG ensures necessary safeguards for, and appropriate use of, patient, staff and business information.

The key objectives of IG are to maintain high standards of information handling by ensuring that information is:

- Held securely and confidentially
- Obtained fairly and efficiently
- Recorded accurately and reliably
- Used effectively and ethically
- Shared appropriately and lawfully

Each year the Trust must submit scores and provide evidence for the NHS IG Toolkit to the Department of Health (DH). Our score for 2009/10 for the Information Quality and Records Management sections, assessed using the IG Toolkit, was 74.6 per cent\*\*.

St. George's has an ongoing, rolling IG programme dealing with all aspects of confidentiality, integrity and security of information. We implement new systems, processes and we ensure that all our staff are aware of their IG obligations to both patients and staff.

A key aspect of this ongoing programme in 2009/10 was the replacement of our patient administration system with a new, modern system, enhancing our ability to provide accurate information to relevant staff and to increase the trust's security and audit capabilities.

### Our IG scores...

You can find the IG Toolkit and our scores on the IG Toolkit website  
Search for us using the organisation type 'Acute' and our NACS code 'RJ7'.

\*\*The IG Toolkit requirements used to calculate this were: 401 to 408, 501 to 511 and 601, 602.



## Clinical coding

Clinical Coding is “the translation of medical terminology as written by the clinician to describe a patient’s complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format” which is nationally and internationally recognised.

The use of codes ensures the information derived from them is standardised and comparable. This coding is used to support many functions within the trust, both clinically and statistically.

### Things to do...

Make improvements to our clinical coding to deliver better efficiency, support patient choice and reduce waiting times

**TABLE 1**

Area audited	Specialty/Sub-chapter/HRG	% procedures coded incorrectly		% diagnoses coded incorrectly	
		Primary	Secondary	Primary	Secondary
Theme	General Medicine	31.7	15.7	30.0	39.2
Specialty	Gynaecology	12.6	24.8	21.0	43.9
Sub-chapter	HD Musculo-skeletal disorders	15.4	16.7	27.1	28.9
HRG	CZ17Y Intermediate Maxillofacial Procedures 10 years and over without CC	6.7	13.9	23.3	55.2
<b>Overall</b>		<b>16.2</b>	<b>19.0</b>	<b>25.7</b>	<b>37.9</b>

TABLE 1 outlines the error rates reported in the latest published audit for 2009/10 for diagnoses and treatment coding:

St George’s was subject to the Audit Commission’s Payment by Results (PbR) clinical coding audit during 2009/10. The aim of PbR is to provide a transparent, rules-based system for paying trusts. It aims to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payments are linked to activity and adjusted for dependence on the type of patients each trust cares for.

The areas audited were selected by the Audit Commission to benchmark our performance against national coding. Therefore, these figures are not necessarily accurately representative of the Trust coding quality as whole.

Overall however, our coding performance was less accurate than in 2008/09 which is very disappointing. It’s important to make it clear that this isn’t a patient safety issue, but errors in our clinical coding rate do affect how efficiently we can manage a patient’s journey through the trust. We are working hard to recruit experienced clinical coders (of which there is a national shortage) and have put an action plan together that has been agreed by the South West London Acute Commissioning Unit.

We fully intend to report back on this in the quality account for 2010/11, showing precisely what measures have been taken and where improvements have been made.



# Improving patient safety

**Patient safety is at the heart of everything we do at St George's, and our staff are continuously looking at ways to improve the care we provide, based on appropriate clinical audits and implementing the latest research**

## Prevention of falls

A falls prevention committee was established to provide strategic leadership and expertise, so we could deliver recommended measures from the National Institute for Clinical Excellence (NICE) to help prevent falls and injury from falling. The trust introduced a hospital falls policy, which is regularly evaluated and developed assessment and intervention tools.

The falls prevention committee is a multidisciplinary team consisting of doctors, nurses and therapists as well as health and safety professionals and falls co-ordinators from neighbouring primary care trusts.

The committee provides guidance on the quality of care and service required to improve processes to reduce the incidence of falls. The group also monitors slips, trips and falls and highlights areas of concern to the relevant health care professionals. They also provide advice on the safe design and maintenance of trust property, ensuring that the prevention of falls is always considered.

We have in place a pathway for inpatients presenting with falls or who are at risk of falls. Nurses use a tool known as STRATIFY to assess patients on admission to the ward, which helps the team to measure the likely risk of falls on the ward for that particular patient.

For those patients assessed to be at medium to high risk a multidisciplinary care plan is commenced to reduce the chances of them falling. When discharged, patients are then referred to a community setting of their choice for continued falls prevention interventions. A specific pathway is also in place for patients presenting to A&E with falls.

Approximately one thousand elderly people are admitted to St George's each year following a fall. Clinical staff are now provided with falls training and we have established good links with partners in primary and community care. We participate in national audits to benchmark our performance and our action plan is featured on the Royal College of Physicians website [www.rcplondon.ac.uk](http://www.rcplondon.ac.uk).

As a result of some of this work the number of older people re-attending A&E or being readmitted due to a second fall has decreased since 2008. The number of inpatient falls increased slightly (4%) in 2009, however, we believe this may be due to increased reporting.

## Things to do...

Reduce numbers of falls in hospital and the community and improve our reporting to measure against more accurate figures



## Infection control

The prevention and control of hospital acquired infections at St George's is a top priority. Our aim is to make the hospital as clean and safe for patients as possible. Alongside the cleanliness of our wards, we continue to focus on our programme of comprehensive training for staff, stringent hand hygiene and careful use of antibiotics.

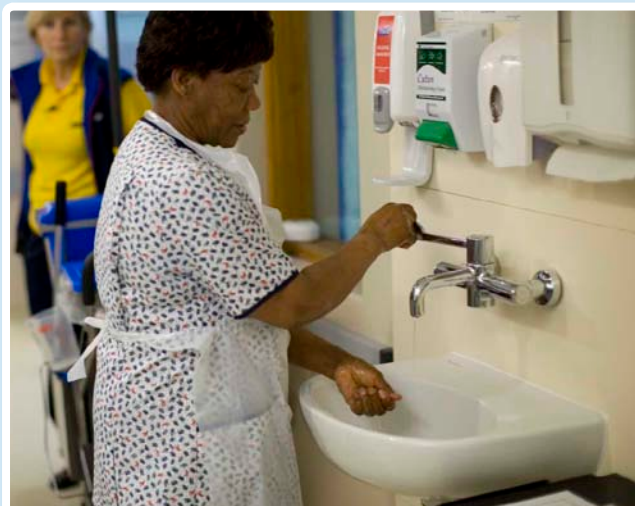
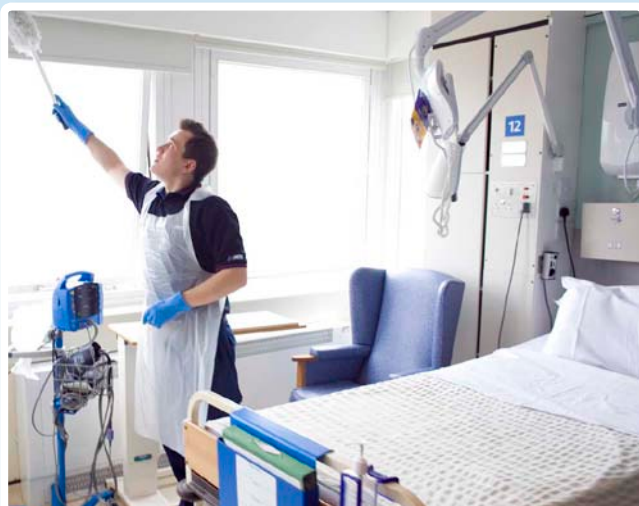
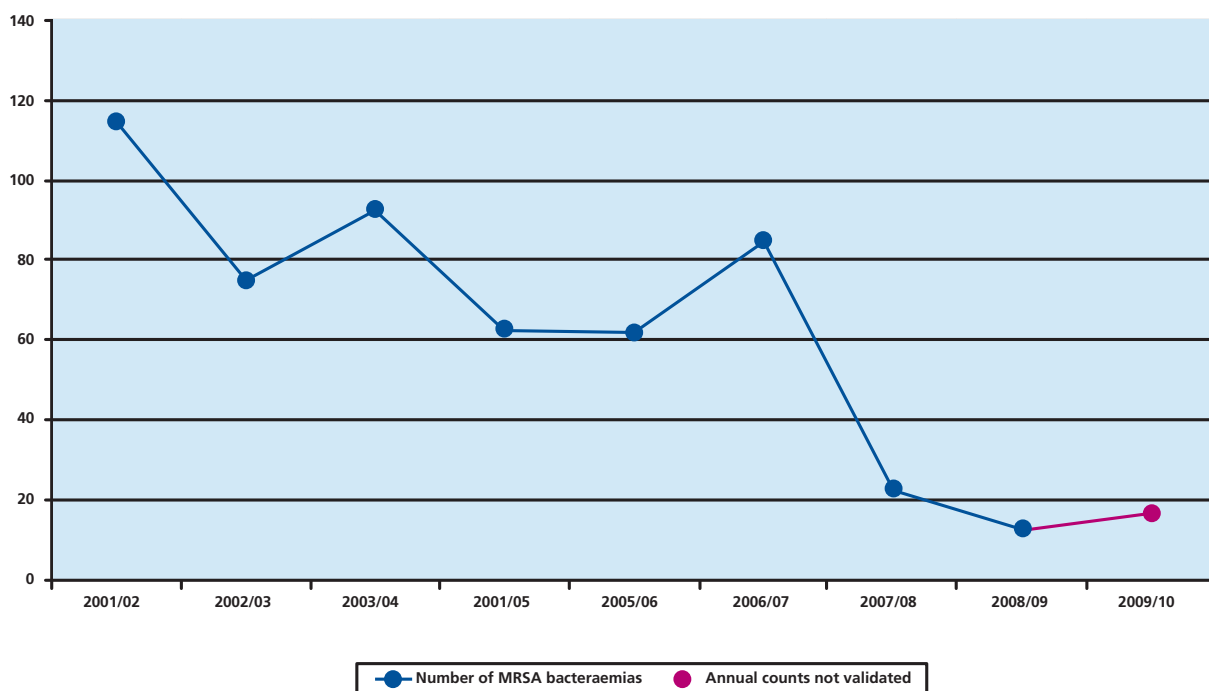
Our infection control team works around the clock, monitoring infections and providing ward staff with advice on how to treat and prevent the spread of bacteria and viruses. A programme of ward deep cleans, using a combination of chlorine based detergents and steam, combined with the latest high powered equipment, has helped to tackle infections and improved the overall hospital environment.

There were just 17 recorded MRSA infections at the Trust during 2009/10. This figure is 64 per cent lower than our mandatory target for the year which was no more than 47 infections during the year. We narrowly missed our ambitious voluntary target, which was no more than 12 infections. A new mandatory target of nine has been set for 2010/11.

One future action which may help reduce MRSA acquisitions is the introduction of screening for all emergency admissions, which commences in 2010-2011. Screening of all admissions (elective & emergency) at the Trust will begin in October 2010 to ensure the Trust meets the Department of Health requirement to have universal screening of admissions established by December 2010.

**GRAPH A:** St George's has achieved a consistent downward trend for MRSA infection over the last five years

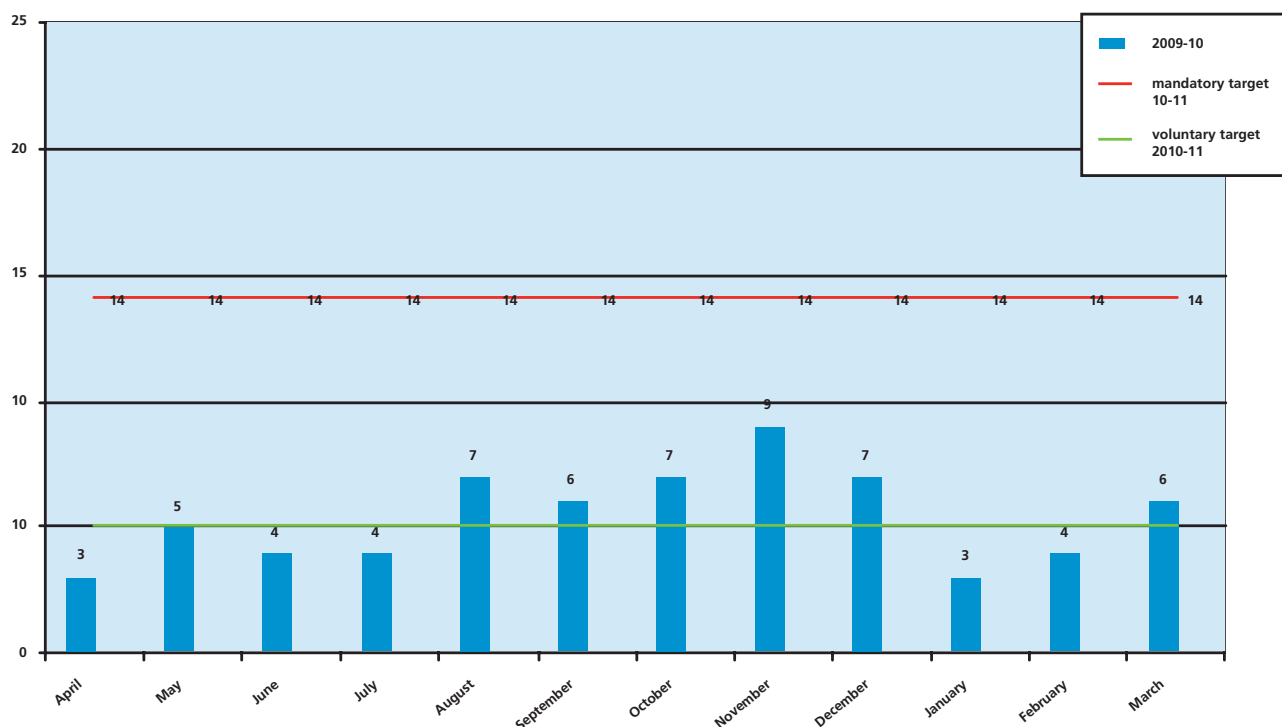
**Annual MRSA bacteraemia counts since 2001/02**



The cumulative total of Clostridium difficile (C.diff) infections for 2009/10 was 65 against a voluntary target of 70 for the year 2009/10. This is 73 per cent below the mandatory target for the period, which was 237. Consequently, the Trust has met both the voluntary and mandatory targets for C.diff.

**GRAPH B:** St George's has achieved a consistent downward trend for C.diff infection over the last five years

**Monthly number of attributable cases of Clostridium difficile infection at St George's Hospital 2010-11 with monthly mandatory targets and monthly totals from 2009-10 at 26th May 2010**



The trust received an unannounced visit from the CQC in November 2009, and was inspected against 16 sub-duties of the Hygiene Code, focusing on areas of activity relating to infection prevention and control. No breaches were reported and our rates of C.diff and MRSA were lower than the rates at the majority of similar trusts. The report recommended one area for improvement which was the cleaning of extraction vents which was completed immediately.



### Things to do...

Maintain our low C.diff and MRSA figures and remain one of the top performing teaching hospitals in England for infection control



## Incident reporting

The complexity of modern healthcare means that things can occasionally go wrong even with the best intentions or practices and procedures in place. Our staff are proactive in assessing and managing risks to make sure the environment and our procedures are as safe as possible so that we can deliver the very best healthcare to our patients. The trust employs relevant policies and procedures to investigate and identify failures or deficiencies and learn from those incidents or complaints.

Our adverse incident policy sets out the trust's arrangements for the reporting of incidents and near misses with the aim of reducing harm caused to our patients or staff, by ensuring that any lessons learnt from investigations are acted upon promptly so that recurrences can be avoided.

It is the trust's aim to complete all SUI investigations within 60 days. We are putting processes in place to meet this aim and will report back on the outcomes of that strategy as part of our performance measures in the 2010/11 quality account.

Incidents are reported using an electronic incident reporting form. These are then assessed and graded according to their severity, and investigated accordingly. Serious untoward incidents (SUIs) are investigated using a root cause analysis and the completed investigation reports or 'action plans' are shared appropriately. The trust is also required to report patient safety incidents to the National Patient Safety Agency and other agencies as per statutory and mandatory requirements.

Completed SUI investigation reports, action plans and audits are presented to our patient safety committee. Regular reports on trends and patterns are also presented to the trust's health, safety and fire committee and the divisional health & safety committees, so that lessons that can be learnt and disseminated throughout the hospital.

## Where we've improved practices...

Some examples of where the Trust has changed practice and improved processes as a result of lessons learnt from incidents or complaints:

- Introduction of a formal structured risk assessment tool in triage to ensure midwives assess, plan and provide safe/appropriate care to women assessed at triage areas in maternity.
- Introduction of Situation Background Assessment Recommendation (SBAR) – a structured tool to ensure effective communication occurs when care is handed over from one healthcare professional to another. This will help prevent/reduce errors caused from breakdown in communications. An audit is taking place in 2010/11 to review how well the SBAR tool is being used.
- Review of how category 1 caesarean section calls are made. The guidelines were revised to ensure clarity and prevent miscommunications/delays between multi professional teams

## Things to do...

Put processes in place which allow all serious untoward incident investigations to be completed within 60 days



## Executive walkabouts

The executive walkabout is an initiative initiated in 2009 by the Board which has two main aims – to do the best that we can as an organisation to protect the safety of patients, and to help directors learn more about the patient experience and views of front line staff.

Two executive directors visit selected ward areas and/or other parts of the hospital. All our directors take part, and the visits last around one hour. The directors discuss their findings at their weekly meetings including any actions they agree are needed.

We hope this initiative will improve two-way communications between directors and front line staff. The visits also allow staff to raise any issues with the directors in a more informal setting.

Looking forward to 2010/11 the Trust has made provision to appoint a patient safety manager. This new post will lead on the patient safety agenda for the Trust, ensuring that processes and policies are in place and under continual review so that patients receive the safest possible care at St George's.



## Safeguarding children

Our staff work hard to ensure that all patients, particularly children, are cared for in a safe, secure and caring environment. As a result, a number of arrangements to safeguard children are in place.

St George's meets the (NHS) statutory requirements in relation to the Criminal Records Bureau (CRB) check. All staff who work clinically, or have regular contact with patients during the course of their duties, receive enhanced CRB clearance.

The Trust Safeguarding Children Policy was updated in September 2009 and will be reviewed again as new guidance comes out or formally in three years which ever is sooner.

We have a robust process in place for following up children who miss appointments. Any child who does not attend have their notes reviewed by the consultant in charge of their care. This process is under review by the Named Doctor for Safeguarding.

The Trust also has a system in place for identifying children of Wandsworth, Lambeth, Merton and Sutton, as they come through the A&E department, for whom there are child protection plans in place. The Named Doctor for Safeguarding is working with the information technology team to ensure that the new computerised patient record has the ability for the whole Trust to be able to identify children of concern.

The trust has named professionals who lead on issues in relation to safeguarding. They are clear about their roles and receive support and training which includes close contact with other social and health care organisations.

The director of nursing and patient safety is the executive director lead for safeguarding children and a Safeguarding Committee is in place which reports to the Board on safeguarding children.

The trust Board takes the issue of safeguarding extremely seriously and receives an annual report on safeguarding children issues.

### Things to do...

Increase the time available for named professionals to do their work

A full public statement on our safeguarding measures is available on the trust website [www.stgeorges.nhs.uk](http://www.stgeorges.nhs.uk).

# Increasing clinical effectiveness

## Mortality (death rates)

The mortality level at St George's as a whole has been significantly better than the national level throughout the last year. This maintains the excellent performance observed in recent years.

In 2002 the trust invested in a mortality monitoring system, one of the first in the UK, which compares death rates with the expected average, both at St George's and at other hospitals of a similar size that treat similar patients.

A mortality monitoring group, comprising senior clinicians and members of the clinical effectiveness team, meets regularly to examine the data and look for patterns or trends of concern. The data is also monitored in 'real time' as it is entered onto a computer database.

The system now operates in 30 specialities, providing a comprehensive and almost instant snapshot of clinical outcomes across the trust.

The system highlights unexpected rises in mortality data. Once a trend is spotted, the group launches an investigation looking at why death rates are rising and whether this indicates a problem with care at St George's, or a wider problem in the community.

Patient notes are examined to see if anything could be done differently and clinicians from relevant departments are asked for their views. Used together with our systems for benchmarking our performance against expected other NHS hospitals, we believe our mortality monitoring system enables us to identify very recent changes in the context of detailed overviews of clinical outcomes

In an exciting new development for St George's, the same systems are now being developed to create an early warning system that will show when patients are staying in hospital for longer than necessary.

As with mortality monitoring, a group will meet regularly to discuss length of stay in wards across the trust, and where patients are staying longer than necessary, the reasons behind the trend will be scrutinised and solutions sought. The system is expected to lead to shorter waiting times for patients and a more efficient hospital.

We believe the trust will be one of the first in the world to implement this system and expect it to deliver significant benefits for patients, allowing them to access services more quickly and to recover in the comfort of their own homes as soon as they are clinically able to do so.

## How audit improves care

Clinical auditors also play an important role, bringing the latest research techniques to the wards, and assessing whether these new techniques are beneficial to patients. In one such case, a new protocol was introduced for patients coming to St George's for angiography, a type of x-ray that examines the inside of blood vessels, arteries, veins and chambers of the heart.

The test is carried out as a day case and involves a contrast agent, or dye, being injected into the jugular or femoral vein. Previously patients would rest for around four hours after the test, but following research carried out at St George's, the amount of time they spend resting has been reduced to just two hours. These patients also found that they felt better and had fewer complications as a result

This two-hour guideline is now in force for all angiography patients, which illustrates where audit can change practice, and patients are benefiting as a result. The study was published in the British Journal of Cardiology, and is being presented at both the International Forum for Quality and Safety in Health Care and the Patient Safety Congress.



## Benchmarking

The Trust regularly assesses its performance in relation to expected levels defined by the Dr Foster system. The levels – including information relating to mortality, length of stay and readmissions – are based on the performance of all NHS hospitals. By using this approach we are in a position to identify where our performance is particularly strong and areas in need of further consideration.

We do recognise however that our benchmarking methods could be more robust so in 2010/11 we intend to improve our measures so that we are in a better position to compare our own performance against that of similar organisations and key quality indicators. We are fully committed to learning from our own experiences and the experiences of others in order to improve our services for patients.

## Things to do...

Introduce a range of quality and safety metrics to learn more and compare St George's more meaningfully against similar organisations





# Dr Foster Intelligence, the publisher of the Hospital Guide, has named St George's as its 'Large Trust of the Year'.

Each year, Dr Foster Intelligence aims to give patients the information they need to exercise choice of hospital with its guide which is based on analysis of the routine administrative data (Secondary Uses Service data) and information collected directly from acute trusts in a self-assessment survey.

St George's was awarded one of the top scores and the top 'band 5' rating across thirteen safety indicators. We received 97.26 out of 100, placing the trust joint third in a ranking of participating trusts. Dr Foster recognises four outstanding acute trusts, one overall winner and one trust in three size categories – small, medium and large – and St George's took the title of 'Large Trust of the Year'.

Chief Executive, David Astley, said: "This award is recognition of the great strides that St George's has made in recent years. During 2009, our infection control rates have been among the lowest of any London Teaching Hospital and we were successful our bids to become a major trauma unit and a hyper-acute stroke unit.

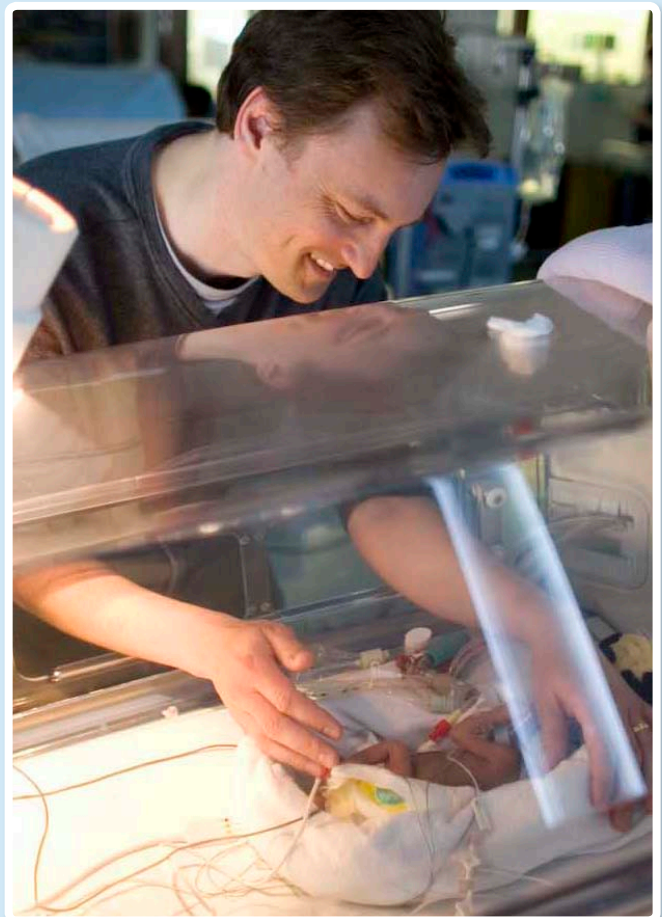
The Guide reports that St George's has significantly lower than expected mortality rates in a year (2008/09) when the overall mortality rate improved. St George's was also highlighted as following best practice for heart attack patients as it offers more than 90 per cent of its patient primary angioplasty as an emergency treatment.

"The progress we have made would not have been possible without the dedication of our staff it is through their hard work and commitment that the Trust continues to go from strength to strength."

Dr Foster is the UK's market-leading provider of information, analysis and targeted communications to health and social care organisations. The Hospital Guide can be found at [www.drfoosterhealth.co.uk](http://www.drfoosterhealth.co.uk)

"Dr Foster's Guide this year focused on patient safety and St George's has been recognised as being one of the five leading Trusts in England in this area, as well as for providing quality services for patients."

dr foster®  
**intelligence**  
**2009**  
large trust of the year



## Clinical audits

By being able to compare the care patients receive against carefully constructed guidance, based wherever possible on the best available evidence from research, hospitals are able to identify in various ways where there are areas for improvement in clinical services. When we have established points in a pathway of care where further developments can be introduced we can then subsequently re-examine how well the changes may have worked.

This cycle of examining the quality of care, against evidence based standards, through clinical audit, provides a system for ensuring the services we provide to patients are improving in a direction consistent with the best available guidance.

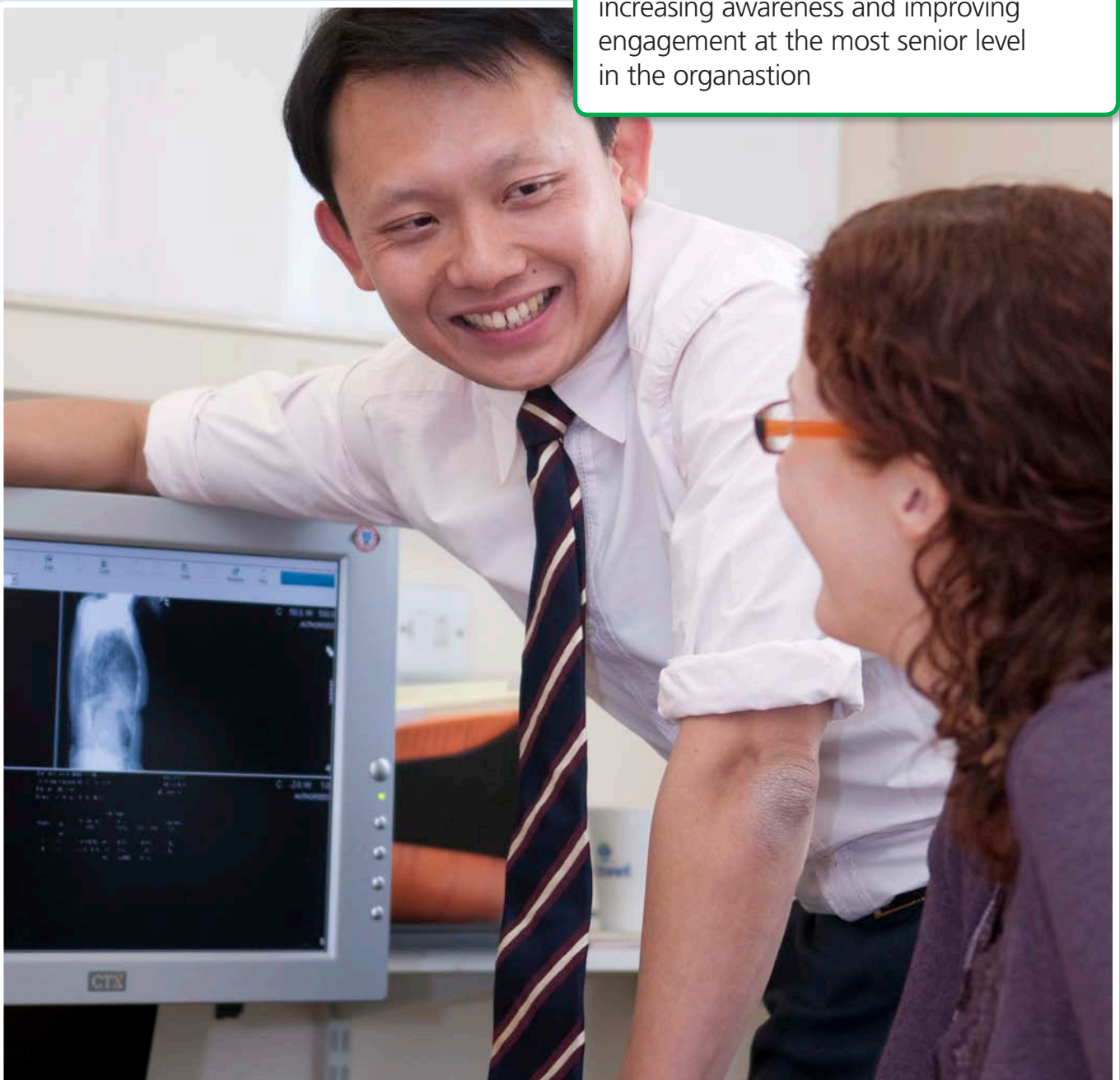
St George's has established an audit team covering each speciality and care group, helping to improve the quality of audits carried out. The clinical effectiveness team also provides training to staff across the hospital, and the number of people taking part in this training has increased.

St George's annual trust-wide clinical audit half-day was held in December 2009. Over 170 people attended this event which showcased the work of clinical staff, therapists and medical students working throughout the trust. The event featured oral presentations on a variety of topics including cellulitis prevention in lymphoedema services, clotting studies, wrong-sided surgery and thromboprophylaxis prevention.

In addition, over 60 poster presentations were displayed, each one demonstrating the depth and breadth of talent to be found at St George's as well as an overriding commitment to providing the best possible care for our patients. Guest speakers, Dora Kamugasha and Penny Peel from the Royal College of Physicians gave an overview of National Audits.

### Things to do...

Improve audit reports at Board level, increasing awareness and improving engagement at the most senior level in the organisation



## Productive ward – releasing time to care

The productive ward programme (PW) helps teams at St George's to reorganise and redesign the way they manage and operate in the workplace. It adopts efficiency techniques previously used in motor car manufacturing, together with safety techniques used in the aviation industry. It hinges on the principle of getting the right things to the right place, at the right time, in the right quantities, while minimising waste and being flexible and open to change.

Simply by getting better organised it has helped our staff to achieve significant improvements by increasing the amount of time nursing teams are able to give directly to patients, which in turn improves quality of care.

The key to the success of PW is that improvements are driven by staff themselves – those best placed to see where improvements and efficiencies within their areas of responsibility can be found. This empowerment allows opportunities for positive change in areas of practice, while promoting a continuous improvement culture.

The process has also helped us to make savings in materials and reduce waste, as well as improve staff morale, by helping people to make positive changes in the workplace and get the most out of their roles.

PW was implemented across 21 clinical areas at St George's during 2009/10, which included 479 patient bed areas. The programme delivered an overall increase in direct patient care from 37 per cent to 59 per cent, with some clinical areas showing considerably more direct time spent with patients.

Monthly board meetings chaired by the Chief Executive ensure that feedback from 'ward to Board' is achieved. Achievements made in one clinic area are then shared with other departments across the Trust who can then make similar changes to suit their environment.

## We have freed up more time to care....

As a result of the implementation of the Productive Ward programme the time our nurses spend giving direct care to patients increased from 37% to 59%

### Benefits for patients...

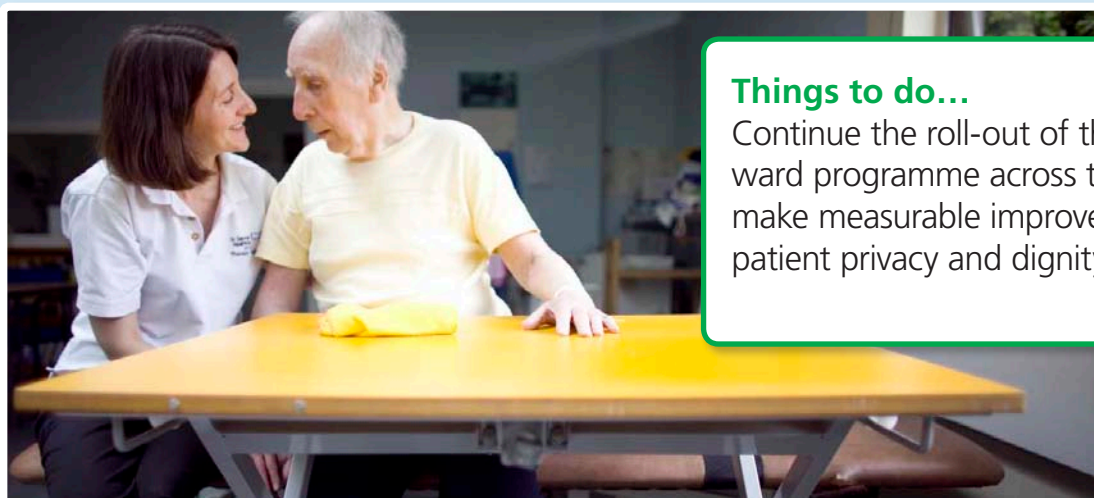
- Increase in the time staff have for patients
- Increased direct care
- Quicker recovery time
- Better experience of hospital stay
- Ward processes that are safer and more dignified for patients
- Improved staff morale
- More organised processes
- Calmer ward environment

### Benefits for our staff and the Trust...

- Increase in Direct Patient Care Time
- Decrease in staff sickness
- Calmer work environment
- Promotion of professional development
- Increase in staff satisfaction
- Less frustration
- Empowerment
- Ownership

Looking ahead we are continuing to implement PW across the Trust and will continue to monitor where the programme is having a positive effect on productivity. We are also looking into how elements of PW processes can be applied to other important initiatives such as improving patients' privacy and dignity.

Patients are involved in our work around PW at a local level together with other initiatives in place to improve the patient experience at St George's. The Trust also monitors patient engagement through patient complaints, service user groups and patient stories.



### Things to do...

Continue the roll-out of the productive ward programme across the trust and make measurable improvements to patient privacy and dignity



# Improving the patient experience

## Same sex accommodation

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. St George's is committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

We are proud to confirm that mixed sex accommodation has been virtually eliminated in our trust. Patients who are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen by exception based on clinical need, for example where patients need specialist equipment (such as in neuro, cardiac and general intensive care, coronary care, hyper acute stroke unit, clinical decision unit with the emergency department and paediatric intensive care).

Our full same sex accommodation declaration is on the trust website [www.stgeorges.nhs.uk](http://www.stgeorges.nhs.uk).

## Patient Experience Trackers

Patient Experience Trackers (PETS) are electronic devices that measure patient satisfaction, using questions tailored to meet the information needs of the department. The information provided is accessed on a weekly basis and actions are updated locally to ensure the highest standards are maintained throughout the Trust.

Each PET has five questions which can be reviewed as necessary. They are based entirely on the patients' perceptions of the care they are receiving and the environment around them. They enable ward areas to address any issues locally in a timely manner as the information is provided in 'real time'. At any time, selected staff can access the results and customise reports in order to gain detailed and specific information about any given area that is using a PET (see GRAPH 1).

PETs are one of a number of ways we glean patient feedback and are in place in 41 clinical areas at St George's, including wards, maternity, outpatients and critical care areas and we will be introduced in more areas around the Trust to gain a broader, more comprehensive view of patient satisfaction.

## Establishing a better hospital environment

St George's has made significant efforts to improve the hospital environment for patients. It is a key corporate objective for us to ensure care is provided in environments that are safe and promote patient and staff well-being – a commitment which is reflected in our PEAT results.

The Patient Environment Assessment Team (PEAT) is an annual assessment of inpatient healthcare sites in England with more than ten beds.

PEAT is self assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas).

The assessment was established in 2000 and is a benchmarking tool to ensure improvements are made in the non-clinical aspects of a patient's healthcare experience. The assessment highlights areas for improvement and shares best practice across the NHS.

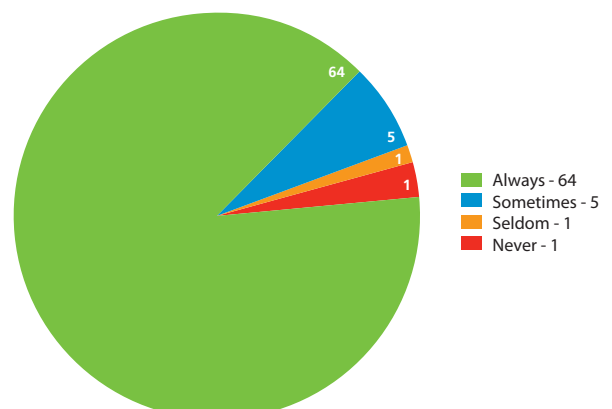
NHS organisations are each given scores from 1 (unacceptable) to 5 (excellent) for standards of privacy and dignity, environment and food within their buildings. The NPSA publish these results every year to all NHS organisations, as well as stakeholders, the media and the general public.

In 2010 our 'Environment' score rose from Acceptable (3) to Good (2) and our 'Privacy & Dignity' and 'Food' scores remained Good (2).

You can view the results from St George's PEAT assessments via the **National Patient Safety Agency website**.

**GRAPH C:** Example of a weekly report showing a corporate question asked in every ward

Do you feel that you have been well cared for whilst in this department?





## Nutrition and hydration

**'Nothing shall be done in the ward whilst the patient is having their meal'**

Florence Nightingale 1851

Patient nutrition and hydration are a high priority at St George's and there is a designated nutrition strategy committee to ensure the best possible nutritional status is achieved for our patients. Menus are continuously reviewed by dieticians and our staff work to ensure that different types of diet to suit all medical conditions and dietary requirements are available.

On admission to hospital all our patients are screened for risk of malnutrition using the Malnutrition Universal Screening Tool (MUST), devised by the British Association of Parenteral and Enteral Nutrition (BAPEN). This important tool is audited twice a year and has been adapted by our dietetic team to ensure we comply with evidence based practice.

We believe that our health service should be organised around the needs of the patient rather than the needs of the professionals, so our wards implement a protected mealtimes policy, which ensures that all non-urgent clinical activity (e.g. ward rounds, drug rounds, non-urgent testing etc) stops during patient mealtimes. This means that patients are able to eat uninterrupted and staff can spend time offering assistance.

Research shows that patients who are not interrupted and receive appropriate service and support during mealtimes are happier, more relaxed and eat more. In many cases our wards also have day rooms so patients are able to eat at a table away from the bedside. We audit the protected mealtime yearly to ensure compliance and to highlight areas where improvements can be made.

While our audits show a general improvement over the last three years it has also identified where we can make further improvements. These results are always shared with our ward sisters and charge nurses so that action plans can be developed and quickly implemented on the wards.

Patients on our wards who require assistance with eating are allocated a red tray. This allows nursing staff to identify at a glance which patients need extra help at mealtimes. Nurses at St George's are always involved with the delivery of food to patients in close cooperation with the ward hostesses. Our wards also use food charts to record each patient's dietary input.

The Trust has also introduced an initiative which provides training to provide volunteers with the skills to help patients eat their meals on our elderly care wards. The intention is for this valuable initiative to roll out to other areas across the Trust in 2010/11.

### Things to do...

Improve the support available for patients who need help during meal times



## Managing complaints

St George's is committed to and prepared to change, improve and evolve in response to complaints and the need for improvement. The lessons learned and trends identified through information collected through the established complaints process plays a key role in improving the quality of care received by patients.

In 2009/10 we received 897 formal complaints, which represents an increase of 24 per cent on the previous year. In part explained by an increase in activity ie numbers of patients seen and treated in in-patient and out patient settings.

We always endeavor to respond to all complaints within 25 working days, however, in 2009/10 we failed to reach this target. In 2008/2009, 60 per cent of complaints were responded to within the 25 working day target and this fell to 51 per cent in 2009/10 which is below what we would deem to be an acceptable level.

We are putting into place more robust systems in 2010/2011 to improve this and are reviewing our complaint process to make sure we can meet the response rate of 85 per cent in 2010/11. We are also introducing methods of tracking complaints in order to identify those departments where complaints are increasing. The outcomes of this work will be reported in the 2010/11 quality account.

**TABLE 2:**

**At St. George's the most common complaints received in 2009/10 fell within the following five categories:**

Category	2009/2010
Clinical treatment	252
Communication	152
Attitude	107
Waiting times	105
Care	60

The Patient Advice and Liaison Service (PALS) at St George's helps to address any problems or concerns that patients may have regarding the Trust's services. The service listens to the views and comments of patients and can provide them with access to interpreters, signers and other services they may need to improve their experience at the Trust. PALS also provides customer care training to staff throughout the Trust and often assists staff when they are in need of support.

The contacts received by PALS are placed in two categories:

- Category A (Contacts) refers to any enquiry or request that does not raise areas of concern within the Trust. For example, a contact may be a patient wanting information about a service or a member of staff seeking advice about how to contact an outside organisation. Also included in this category are patients and relatives who expressed thanks.
- Category B (Concerns) refers to when a patient or relative has raised a concern about the Trust but does not wish to follow the formal complaints procedure.

The PALS department was contacted on 5954 occasions for help and assistance during 2009/2010, which shows an increase of 34 per cent from the previous year. 66 per cent of these contacts fall under Category A (Contacts). (see TABLE 3)

**TABLE 3:**

**The number of contacts St George's received in 2009/10**

Type	2009/2010
A Contacts	3950
B Concerns	2364
Total	5954

**TABLE 4:**

**The most common PALS concerns in 2009/2010 fell within the following five categories:**

Subject	2009/2010
Appointments	547
Communication	468
Request for Information	272
Care	197
Patient transport	194

### Things to do...

Tracking complaints more efficiently and putting measures in place to implement improvements in departments where concerns are increasing, helping the trust to meet the 85 per cent complaints response rate within 25 days

## Interpreting services

Based in Tooting, southwest London, St George's serves one of the most diverse communities in the country, and for many local residents English isn't their first language. We are committed to providing the very best services for all our patients, so we often provide interpreting services for patients from our local community and for any patient that has an interpreting need.

Interpreters were used on a total of 5124 occasions in 2009/10 which is an increase of 20 per cent on the previous year. 91 per cent of usage related to face-to-face interpreting which is the preferred method at St George's. Where it is not possible to arrange a face-to-face interpreter, we endeavour to organise telephone interpreting services.

Interpreters were requested for 55 languages in 2009/10, an increase of 10 per cent. Overall, the top five languages requested were Polish, Urdu, Somali, Tamil and finally Portuguese, which replaces Gujarati from the previous year. The Royal Association for Deaf People (RAD), our preferred provider of British Sign Language interpreters, provided 205 British Sign Language interpreters this year, which represents a significant increase of 25 per cent on 2008/09.

## Improving care for patients with learning disabilities

### What is a learning disability?

A significantly reduced ability to understand new or complex information, and to learn new skills, with a reduced ability to cope. This disability has started before adulthood, with a lasting effect on development.

St George's benefits from a full-time Consultant Nurse in Learning Disabilities, the first role of its kind in an acute care setting, and a permanent appointment since June 2009. Although this type of role exists elsewhere, most of those specialising in learning disabilities work in the community, or in a mental health trust or learning difficulty trust.

We are therefore at the forefront of dealing with an important issue – that people with learning difficulties have a higher than average attendance at hospital, but their experience of care and their outcomes can be poorer than average. Even more seriously, people with learning difficulties have died unnecessarily in hospital because of failures to understand or address their particular needs. A report Death by Indifference published by the charity Mencap in 2007 highlighted this and demanded action to address the situation.

The Nurse Consultant is involved with the admission, treatment and discharge of patients with learning difficulties throughout the Trust. Three-quarters of those patients have an acute medical need and are referred by the ward when they are admitted. Other referrals come from Learning Disability (LD) Nurses in the community who know their patients are coming in for planned treatment, and from parents and people with learning disabilities themselves. The Nurse Consultant maintains close relationships with LD professionals who work in other settings, and identifies the patients who come under their care so that information can be quickly shared. This in turn ensures that clinical staff at St George's understand a patient's particular needs, contributing to a better and safer care.

The role itself leads on changes across the Trust to ensure that, wherever possible, clinical practice and protocols address the needs of people with learning disabilities. This has included recruiting Learning Disability Champions from among clinical staff who can take forward the aim of raising awareness and making changes.

A group has been established at St George's, comprising parents of children and adults with learning difficulties who want a dialogue with education and health and social care professionals in order to develop services. The group, LD Caring Solutions, aims to share concerns and identify priorities.

A pioneering scheme, resulting from work between our staff and the Wandsworth Community Learning Disability Team (CLDT), won a £2,000 Foundation of Nursing Award last year. The Hospital Passport scheme provides vital information to hospital staff about patients with learning disabilities in the event that a patient is unable to communicate their needs effectively. The passport is retained by the patient, and he or she controls what information is included in it – carers can also contribute to the passport contents and assist in completing it.

**"The Hospital Passport has proved an effective way to help people with learning difficulties cope in a hospital environment, which can be stressful for anyone. It is very satisfying to see the scheme recognised through this award."**

**Sue Cooper, Safeguarding and Learning Disability Lead at St George's**

The initiative follows research by mental health charity MENCAP which shows that people with learning disabilities struggle to get equal care in hospital. The passports are now in use throughout the Trust and hospitals in southwest London have expressed an interest in introducing similar programmes.



## Inpatient survey results 2009

The care quality commission (CQC) recently published the results of the 2009 NHS inpatient survey. The survey, which covers 162 hospital trusts in England, was undertaken by The picker institute europe.

The 2009 results for St George's indicate that while the majority of our patients were generally positive about their care, there are key areas of work that leave room for improvement. Disappointingly, the results are poorer than previous years.

While we do good work around the trust, and the Dr Foster 'large trust of the year' 2009 is indicative of this, the survey suggests that in some cases patients have not received the excellent experience they expect.

It is important that we never lose sight of getting the basics right and this begins with thinking about how we communicate with our fellow colleagues and how we communicate with our patients. We need to think about how well we prepare our patients undergoing operations and procedures and how we engage and involve patients in the discharge planning process.

Although it is clear we deliver care in a clean, safe and comfortable environment for our patients – 86 per cent rate their care as, good, very good or excellent – there are some clear areas where improvements must be made, particularly in terms of how we communicate with patients.

A robust action plan is being developed to ensure that we tackle the problems head on and work to support and improve the areas that are not performing well.

## Summary of St George's 2009 NHS inpatient survey results

### Positive results

- 86% of patients at the trust rate their care as good, very good or excellent
- 87% said doctors and nurses worked well together
- 94% said wards were very or fairly clean
- 87% who used toilets said they were very or fairly clean
- 84% always had enough privacy when examined or treated

### Negative results

- 55% weren't fully told side effects of medications
- 50% of respondents wanted to be more involved in decisions about their care or treatment
- 50% of respondents were not fully told how they would feel after operation or procedure
- 46% did not feel involved in decisions about discharge
- 58% said their family weren't given enough info to help
- 40% said that staff contradicted one another
- 50% who needed support during mealtimes did not receive it

### Things to do...

Improve the way we communicate about the care we provide and work more closely with patients to improve discharge arrangements





## Developing our workforce

At St George's we recognise the link between high-quality working practices and high-quality care, so we set a key objective in 2009/10 to be an exemplary employer.

We use the annual staff survey to measure our success, and although many indicators in the 2008 survey were positive, there were sufficient areas of concern for the Trust that, in 2009, as well as launching a three year strategy to secure improvements, we would survey all 6,000 staff to enable action in the second year of our strategy to be targeted at clinical service level. 2,730 staff responded, a return of 48 per cent, providing the most accurate picture yet of what it is like to work at the Trust.

St George's is making positive progress in a number of areas, and some of the improvement projects introduced as a result of feedback from the 2008 survey are beginning to have the right effect.

We scored favourably in the following areas, which indicate that we are meeting the four pledges to staff enshrined in the NHS Constitution. In each we have seen significant improvement and/or we are in the top 20 per cent of acute Trusts in the country:

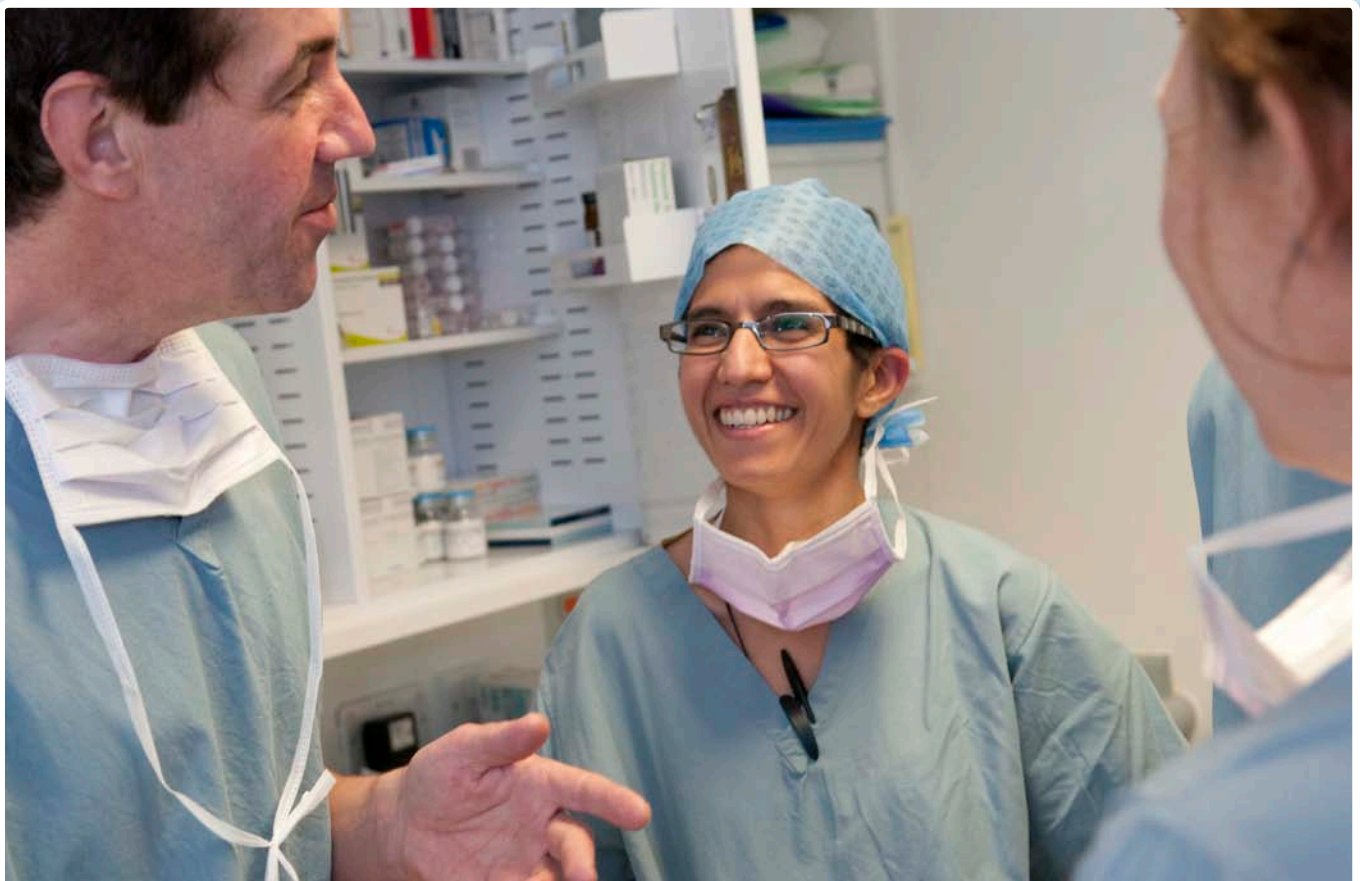
- Coverage and quality of appraisals
- Quality of work and patient care our staff feel they can deliver
- Staff feeling they can make a difference
- Staff recommending St George's as a place to work
- Levels of health & safety and diversity training

However, we know there is still work to do in a number of key areas and must maintain our efforts to secure improvements on all fronts at St George's. Our scores in the following areas have deteriorated and/or we are in the bottom 20 per cent of acute Trusts in the country:

- Bullying and harassment
- Stress and overwork
- Work related injuries
- Discrimination
- Equal opportunities in career development and promotion

The three year strategy at St George's is well underway, with the introduction of the innovative project One Team at St George's, a programme of service excellence through the engagement of staff at bands 1 to 4, the development of a bullying and harassment listening and advice line, staffed by volunteers, and a mentoring service for aspiring BME leaders. These initiatives are designed to directly address some of the areas where we have performed poorly, and we are fully committed to making St George's a positive environment to work in for all our staff.

We recognise that good leadership is an essential element in delivering quality patient care, and that clinical engagement in leadership is vital, so in 2009 we launched an Engaging Clinical Leadership programme. Medical Directors, Divisional Chairs, Clinical Directors, and other senior clinical leaders are all included in the programme, which involves a diagnostic element based on 360 degree feedback, input from leading thinkers, action learning sets and project work.



# Acknowledgements

This quality account was produced by the communications unit, St George's Healthcare NHS Trust. Many thanks to the staff and patients of St George's, whose support and contributions made this report possible.

Design by Media Services  
St George's, University of London.

## Contacts

Support from us

The PALS team at St George's offers support, information and assistance to patients, relatives and visitors. The PALS office is open 9am – 5pm weekdays.

T: 020 8725 2453

E: [pals@stgeorges.nhs.uk](mailto:pals@stgeorges.nhs.uk)

## Working with us

If you are interested in a career at St George's, visit the Trust's website [www.stgeorges.nhs.uk](http://www.stgeorges.nhs.uk), or get in touch with our Recruitment Services team.

T: 020 8725 0600

E: [HRRecruitment@stgeorges.nhs.uk](mailto:HRRecruitment@stgeorges.nhs.uk)

## Feedback to us

Please feed back to the Communications Unit and help us improve the information included in the report next year.

T: 020 8725 5151

E: [communications@stgeorges.nhs.uk](mailto:communications@stgeorges.nhs.uk)

## Give to us

Would you like to give to St George's? You can do so in many ways so please talk to St George's Hospital Charity about how you can help.

T: 020 8725 4916

E: [giving@stgeorges.nhs.uk](mailto:giving@stgeorges.nhs.uk)

# Appendices

## Appendix A

### NHS Wandsworth

"We welcome this first quality account from St George's Healthcare NHS Trust. As a commissioner, we strive to ensure that the services provided for our population are of the highest quality, and we recognise the comprehensive systems and processes in place within St George's to ensure its quality. We believe the information presented in this report, which the trust shared with us at an early stage is an accurate reflection of the services provided., and we welcome the evolution of this report in future years to reflect greater patient involvement in the quality agenda and continuing evidence of increases in quality of care for the Wandsworth population."

"Overall, this seems to be a positive account of the quality being achieved by St George's Hospital Trust and the Trust should be congratulated on the improvements it has made.

The report covers a number of valuable areas and brief comments on these are set out below. Although there are a number of important statistics in the report, these would be more useful if they could be set in context by showing trends over time and comparisons with similar Acute Trusts. In isolation, the figures are more difficult to interpret.

### Wandsworth LINK

#### Patient safety

"Performance in reducing the incidence of MRSA and C Diff. is exemplary and reflects the focus which the Trust has placed on this issue over the past few years.

The focus on falls is supported but it would be helpful for there to be a little more analysis of why the number of in-hospital falls has increased beyond the suggestion that it is the result of better reporting. For example, checking the wards with significant increases could help confirm this view.

#### Clinical effectiveness

"The system which St George's has in place to audit clinical mortality also appears to be very effective and seems to have contributed to the Trust achieving successful outcomes for patients undergoing critical clinical procedures. Applying a similar approach to patient lengths of stay is welcomed as this will also help to ensure that patients who are not improving at the expected rate become a focus for additional clinical attention.



Patient experience

"There still seem to be high levels of PALS concerns being submitted and complaints made. This may not be so but, as there are no benchmarks with other similar hospitals or trends over time, it is hard to put St George's performance in context.

The Trust has still not eliminated single sex wards and this failure does add to the poor experience of some patients. Whilst it is recognised that a very busy hospital such as St George's will need to maximise its bed occupancy, it is hoped that the Trust can significantly reduce the need for men and women to share without compromising its throughput.

"The Productive Ward programme has produced substantial increases in the time nurses are available for direct patient contact. It is hoped that the Trust will sustain this improvement and ensure that time regained from better organisation continues to be given to patient care."

### **Wandsworth Adult Care and Health Overview and Scrutiny Committee**

"The Overview and Scrutiny Committee recognises the centrality of quality to the role of NHS Trust Boards, and is fully supportive of openness with the public over the quality of service offered by healthcare providers. However, it remains sceptical as to whether Quality Accounts are the best method of achieving this. Whilst the quality account contains much information on the processes used to manage quality, it does not provide meaningful information on the aspects of service quality that are of most interest to patients, namely experience of services and patient outcomes."

"The Committee recognises the commitment of the Trust Board to service quality and recognises that the Trust generally performs well in relation to mortality rates and has made impressive achievements in reducing healthcare acquired infections and improving quality of care."

"The Quality Account draws attention to the absence of a systematic process of review of service quality and the absence of reporting of clinical audit to the Trust Board, and hopes that these issues will be resolved. In particular, we hope to see systematic process of reporting issues identified through clinical audit and steps taken to resolve them, and would expect that this will feed into any future Quality Account."

"There does not appear to be any very clear overall rationale for the areas selected by St George's as priorities for improvement, nor is it clear how it will be measured whether intended improvements have occurred. However, handling of complaints has been a concern of the Health Overview and Scrutiny Committee for a number of years, and identification of this area as a priority is welcome."

"It should be noted that the statement that 'mixed sex accommodation has been virtually eliminated in our trust' would not be recognised by many members of the public, given the 'small print' that identifies the areas where clinical need over-rides the provision of single sex accommodation. It is to be hoped that the Trust will continue to work on developments that enable a reduction in the number of wards for which exemption from this target is claimed."

### **Richmond LINK**

"The account is well presented but it does have a number of drawbacks that concern us."

"We are surprised that emphasis is given to the analysis by "Dr. Foster". This relies on data from the Trust. Table 1 (p.5) shows a considerable number of coding errors both for procedures and diagnoses. This undermines the comments of "Dr. Foster" and the reliability of many other measures reported. We are disappointed that no clear action plan has been proposed to remedy this deficiency."

"Obviously we approve the values and strategic aims – but there appears to be little evidence of how patients have been engaged in proposing these, or what effect they have had in improving patient experiences."

"A general comment on the account is that many percentages are given. The problem with only providing results in this way is that it does not help us in determining the effectiveness of the measures taken as no numbers are given of either the population to which the percentage refers, or the number affected. A 10% improvement in 100 patients is far better than the same percentage in 10 patients."

Similarly when figures are given it is difficult to assess their significance if they do not refer to the population (patients) at risk. For example falls are far more common in the elderly, so the rate of fall should be related to the number of patients "at risk" aged 65+ years, rather than the number of patients treated."

"We would be helped if we had information on the total number of patients treated in each of the groups – e.g. OP and A&E."

"Although we welcome that the Trust participates in national clinical audits it is necessary for us to be reassured of the quality of the care provided in each of the groups by information of the findings of these audits – highlighting the problems revealed. We are concerned that no clinical audit has been reviewed at Board level – or any action taken."

## Appendix B

**TABLE 5.1**

The national clinical audits and national confidential enquiries that St George's Healthcare NHS Trust was eligible to participate in during 2009/10

Title	Applicable to SGH?
NCEPOD Deaths in Acute Hospitals (DAH) study	Yes
NCEPOD Elective and Emergency Surgery in the Elderly (EESE) study	Yes
Parenteral Nutrition (PN) study	Yes
Surgery in Children (PS) study	Yes
Acute Kidney Injury (AKI) study	Yes
Cosmetic Surgery study – organisational only	Yes
CEMACH: perinatal mortality	Yes
PICANet	Yes
Vascular Society of Great Britain and Ireland VSD	Yes
NNAP: neonatal care	Yes
NDA: National Diabetes Audit	Yes
ICNARC CMPD: adult critical care units	Yes
National Elective Surgery PROMs: four operations	Yes
NJR: hip and knee replacements	Yes
Renal Registry: renal replacement therapy	Yes
NLCA: lung cancer	Yes
NBOCAP: bowel cancer	Yes
DAHNO: head and neck cancer	Yes
Adult Cardiac surgery: CABG and valvular surgery	Yes
MINAP (inc ambulance care): AMI & other ACS	Yes
Heart Failure Audit	Yes
Pulmonary Hypertension Audit	Yes
National Hip Fracture Database	Yes
TARN: severe trauma	Yes
NHS Blood & Transplant: renal transplants	Yes
NHS Blood & Transplant: potential donor audit	Yes
Adult cardiac interventions	Yes
National Kidney Care Audit (2 days)	Yes
National Sentinel Stroke Audit (n=40-60)	Yes
National Audit of Dementia: dementia care (n=40)	Yes
National Falls and Bone Health (n=60)	Yes
National Comparative Audit of Blood Transfusion: Audit of the use of Fresh Frozen Plasma	Yes
National Comparative Audit of Blood Transfusion: National Blood Transfusion Committee	
Usage of Group O RhD Negative Audit Group	Yes
British Thoracic Society: respiratory diseases (2008 COPD Audit)	Yes
College of Emergency Medicine: Pain in children	Yes
College of Emergency Medicine: Asthma	Yes
College of Emergency Medicine: Fractured Neck of Femur	Yes
National Mastectomy and Breast Reconstruction Audit	Yes
National Oesophago-gastric Cancer Audit	Yes
RCO Continence Care Audit	Yes

**TABLE 5.2**

The national clinical audits and national confidential enquiries that St George's Healthcare NHS Trust participated in during 2009/10

Title	SGH participated?
NCEPOD Deaths in Acute Hospitals (DAH) study	Yes
NCEPOD Elective and Emergency Surgery in the Elderly (EESE) study	Yes
Parenteral Nutrition (PN) study	Yes
Surgery in Children (PS) study	Yes
Acute Kidney Injury (AKI) study	Yes
Cosmetic Surgery study – organisational only	Yes
CEMACH: perinatal mortality	Yes
PICANet	Yes
Vascular Society of Great Britain and Ireland VSD	Yes
NNAP: neonatal care	Yes
ICNARC CMPD: adult critical care units	Yes
National Elective Surgery PROMs: four operations	Yes
NJR: hip and knee replacements	Yes
Renal Registry: renal replacement therapy	Yes
NLCA: lung cancer	Yes
NBOCAP: bowel cancer	Yes
DAHNO: head and neck cancer	Yes
Adult Cardiac surgery: CABG and valvular surgery	Yes
MINAP (inc ambulance care): AMI & other ACS	Yes
Heart failure audit	Yes
TARN: severe trauma	Yes
NHS Blood & Transplant: renal transplants	Yes
NHS Blood & Transplant: potential donor audit	Yes
Adult cardiac interventions	Yes
National Kidney Care Audit (2 days)	Yes
National Sentinel Stroke Audit (n=40-60)	Yes
National Audit of Dementia: dementia care (n=40)	Yes
National Falls and Bone Health (n=60)	Yes
National Comparative Audit of Blood Transfusion: Audit of the use of Fresh Frozen Plasma	Yes
National Comparative Audit of Blood Transfusion: National Blood Transfusion Committee	
Usage of Group O RhD Negative Audit Group	Yes
British Thoracic Society: respiratory diseases – 2008 COPD audit	Yes
College of Emergency Medicine: Pain in children	Yes
College of Emergency Medicine: Asthma	Yes
National Mastectomy and Breast Reconstruction Audit	Yes
National Oesophago-gastric Cancer Audit	Yes
RCO Continence Care Audit	Yes



**TABLE 1.3**

St George's Healthcare NHS Trust did not participate in the following audits that covered NHS services that it provides

Title	Explanation
National Diabetes Audit	The methodology of this audit is generally accepted as requiring improvement and as such it is being reviewed. A decision will be made as to whether we participate in the revised audit. Local audit is carried out in the service and the Trust participated in the National Diabetes Inpatient Audit.
Pulmonary Hypertension Audit	Participation in this audit is being considered by service management alongside a review of numerous continuous audit projects in the Cardiothoracic service with a particular focus on resource. Local audit of hypertension has been undertaken and is soon to be published.
National Hip Fracture Database	SGH have been participating in this project since 1st April 2010 and are submitting 100 per cent of required cases.

**TABLE 1.4**

The national clinical audits and national confidential enquiries that St George's Healthcare NHS Trust participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Title	Number of cases as percentage of that required for study
NCEPOD Deaths in Acute Hospitals (DAH) study	57.1
NCEPOD Elective and Emergency Surgery in the Elderly (EESE) study	30
Parenteral Nutrition (PN) study	100
Surgery in Children (PS) study	62.5
Acute Kidney Injury (AKI) study	100
Cosmetic Surgery study – organisational only	100
CEMACH: perinatal mortality	100
PICANet	100
VSSGBI VSD	100
NNAP: neonatal care	100
ICNARC CMPD: adult critical care units in October 2009	100 General ITU, Neuro ITU and Cardiac ITU 100 since joining ICNARC
National Elective Surgery PROMs: four operations	41.2 – taken from "Provisional monthly patient reported outcome measures (PROM) in England April 2009- November 2009. Pre operative data: experimental statistics". Presented participation rates provide an estimate of the true rate. There may be some imprecision due to differences in the months to which the Q1s and FCEs relate as in many cases, patients will complete the Q1 questionnaire weeks in advance of the operation. Participation rates should therefore be used as a guide only.
NJR: hip and knee replacements	100
Renal Registry: renal replacement therapy	100
NLCA: lung cancer	42
NBOCAP: bowel cancer	22.7
DAHNO: head and neck cancer	n=79 – identified in report as an example of good case ascertainment
Adult Cardiac surgery: CABG and valvular surgery	100
MINAP (inc ambulance care): AMI & other ACS	100
Heart Failure	100
TARN: severe trauma	100
NHS Blood & Transplant: renal transplants	100
NHS Blood & Transplant: potential donor audit	100
Adult cardiac interventions	100
National Kidney Care Audit (2 days)	Yes, exact figures not available. Transport – patients made very few returns as had participated in Pan Thames audit of same topic. Vascular Access – have agreed to take part in continuous audit which has not yet commenced.

Continued...

**Table 4 Cont.**

National Sentinel Stroke Audit (n=40-60)	Last audit data collection period was 2008 – 100 (n=80) cases submitted. Next data collection relates to admissions 01/04/10 to 30/06/10
National Audit of Dementia: dementia care (n=40)	Start date 29/03 – 40 cases identified and data collection planned for 19th April
National Falls and Bone Health (n=60)	100
National Comparative Audit of Blood Transfusion: Audit of the use of Fresh Frozen Plasma	100
National Comparative Audit of Blood Transfusion: National Blood Transfusion Committee	
Usage of Group O RhD Negative Audit Group	97.5
British Thoracic Society: respiratory diseases	100 (National COPD Audit 2008)
College of Emergency Medicine: Pain in children	100
College of Emergency Medicine: Asthma	50
National Mastectomy and Breast Reconstruction Audit	132
National Oesophago-gastric Cancer Audit	62
RCO Continence Care Audit	100

**TABLE 5****Title and process for discussion of report**

NCEPOD Deaths in Acute Hospitals (DAH) study

Caring to the End report launched 5 November 2009. Report disseminated to Divisional Chairs and Clinical Leads.

NCEPOD Elective and Emergency Surgery in the Elderly (ESEE) study

Report to be launched by NCEPOD on 11th November 2010.

Parenteral Nutrition (PN) study

Report to be launched by NCEPOD on 24th June 2010.

Surgery in Children (PS) study

Data collection continues until mid May 2010. Some time after this a report will be launched by NCEPOD in 10/11 or 11/12.

Acute Kidney Injury (AKI) study

Insult to Injury report published 11 June 2009. Report and recommendations disseminated to relevant service and clinicians and responses received indicate that 100 per cent of recommendations have been met.

Cosmetic Surgery study – organisational only

NCEPOD hope to launch their report on their website by the end of 2010.

CEMACH: perinatal mortality

A trust specific report is generated by

Centre for Maternal and Child Enquiries. The report for 2009 has not yet been received. The 2008 report has been received and reviewed by the service. It has also been discussed by the trust Mortality Monitoring Group and has been presented to the Patient Safety Committee.

PICANet: There is a yearly report produced by PICANet on all patients, and this is supplemented by local data and local audit and mortality review processes. These input into the PICU senior management and strategy process, and although the PICANET report does not go directly to the Board the Board does review the work and financial and strategic aspects of the unit.

Vascular Society of Great Britain and Ireland VSD

Data entered into the national vascular database are used to generate a national annual report. This is discussed by the service.

NNAP: neonatal care: Reports are generated by quarter and the latest report covers September to December 09. This report is to be presented at the next NNU clinical Governance Meeting in May. There is definitely room for improvement although we do not perform badly compared to other equivalent units.

ICNARC CMPD: adult critical care units

ICNARC reports are normally produced about 6 Months after the data is

submitted, this allows time for the data to be cleaned. We get the data in quarterly reports but also get a full report for the full year. This information is usually discussed at the Divisional performance meetings as well as local meetings.

National Elective Surgery PROMs: four operations: Local updates on participation have been provided to the Patient Issues Committee. "Provisional monthly patient reported outcome measures (PROM) in England April 2009- November 2009. Pre operative data: experimental statistics" published April 8th 2010 to be considered.

NJR: hip and knee replacements: March 2010 all surgeons carrying out hip and knee replacements were told how to look at their own data on the NJR web-site. The service are going to have an open meeting to discuss it in due course. The service's work is of course also subject to the regular departmental audit meetings.

Renal Registry: renal replacement therapy

Reports from the Renal Registry are discussed in the Renal Unit and at the service's audit meetings.

NLCA: lung cancer

Report discussed at Tumour Working Group.

NBOCAP: bowel cancer

Report discussed at Tumour Working Group.

DAHNO: head and neck cancer 4th annual report published in 2009 and discussed at SGH and Royal Marsden joint Clinical Governance half day. Next report due 26th April 2010 and a much higher case ascertainment for SGH is expected.  Adult Cardiac surgery: CABG and valvular surgery  Reports are presented to the Cardiothoracic Clinical Governance meeting. Process being established by service to ensure reports are disseminated and acted on as appropriate.  MINAP (inc ambulance care): AMI & other ACS  Reports of MINAP data are considered at a monthly meeting chaired by the clinical lead, a Cardiology Consultant. Other attendees are A&E consultant, LAS representative, Assistant General Manager for service, Cath Lab Matron and Coronary Care Unit Sister. We discuss each patient who failed the target, discuss actions and follow up each month. This information feeds into our Cardiology Care Groups. Process being established by service to ensure reports are disseminated and acted on as appropriate.  Heart Failure Audit  Report not yet received. Process being established by service to ensure reports are disseminated and acted on as appropriate.  TARN: severe trauma  TARN audit to be discussed at Trauma Clinical Governance meeting April 2010.	NHS Blood & Transplant: renal transplants  Discussed at Renal MDT meeting.  NHS Blood & Transplant: potential donor audit  Discussed at Renal MDT meeting.  Adult cardiac interventions  Reports are presented to the Cardiothoracic Clinical Governance meeting. Process being established by service to ensure reports are disseminated and acted on as appropriate.  National Kidney Care Audit (2 days)  Reports are discussed in the Renal Unit and at the service's audit meetings.  National Sentinel Stroke Audit  Report was published in April 2009 and widely discussed at service governance meetings and at a wider Trust level as part of the regional Stroke service establishment.  National Audit of Dementia: dementia care (n=40)  Report not yet published as data collection only commenced March 2010.  National Falls and Bone Health (n=60)  Presented to Patient Safety Committee. An action plan has been developed by the Falls Forum and is published as an example of good practice on the Royal College of Physicians website.  National Comparative Audit of Blood Transfusion  The results of all internal and external audits are discussed at the Hospital Transfusion Team meeting and then	escalated to the Hospital Transfusion Committee and Patient Safety Committee for information and / or if any urgent actions are required. A detailed action plan has been formulated for the Audit of the use of Fresh Frozen Plasma.  British Thoracic Society: respiratory diseases: National COPD Audit 2008 report presented at Patient Safety Committee, which reports directly to the Board. In response to areas identified a rapid discharge COPD clinic was developed and the service has resubmitted a business case for an early discharge COPD nurse.  College of Emergency Medicine: Pain in children  Planned publication of report April 2010.  College of Emergency Medicine: Asthma  Planned publication of report April 2010.  National Mastectomy and Breast Reconstruction Audit  Report disseminated and discussed at Cancer Directorate level and at Breast MDT operational meeting, and Breast Tumour Working Group.  National Oesophago-gastric Cancer Audit  Final report not yet published as data entry was re-opened and closed again in March 2010.  RCO Continence Care Audit  Report date not scheduled as yet as data collection period ended 29/03/10.
--	--	---

**TABLE 6**

St George's have also participated in a number of national audits that are not included in the list detailed here which was formulated by NCAAG (National Clinical Audit Advisory Group). These are detailed below:

Title	Activity
National Health Promotion in Hospitals Audit	Participated in data collection August 2009. National report awaited.
BPSU – BAPS Intussusception Study	Participated in data collection. Report published February 2010 and disseminated.
National Diabetes Inpatient Audit	Participated in data collection September 2009.
UK Inflammatory Bowel Disease Audit	Report published April 2009.
Cardiac Rhythm Management Audit 2009	Data submitted to CCAD as required by CQC.
Congenital Heart Disease	Data submitted to CCAD as required by CQC.



## APPENDIX C CQUIN summary 2010/11

### ACUTE CONTRACT CQUINS

Goal	Parts	Details
<b>National</b>		
<b>VTE</b> Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism	1a) VTE Risk assessment  1b) prophylaxis	% of all adult inpatients who have had a VTE risk assessment on admission.  % of all adult inpatients who have received appropriate prophylaxis
<b>Patient Experience</b> Improve responsiveness to personal needs of patients		Adult inpatient survey: <ul style="list-style-type: none"> <li>• Involved in decisions about treatment/care</li> <li>• Hospital staff available to talk about worries/concerns</li> <li>• Privacy when discussing condition/treatment</li> <li>• Informed about medication side effects Informed who to contact if worried about condition after leaving hospital</li> </ul>
<b>Regional</b>		
<b>Patient Safety</b> Improve patient safety through the systematic implementation of validated approaches	1a)  1b)	Implement the IHI Global Trigger Tool  Implement the Enhanced Recovery Programme (ERP) across a minimum of 2 specialities (inc. urology)
<b>Discharge</b> Improve patient safety through the systematic implementation of validated approaches	1a) inpatient discharge information  1b) effective discharges within a hospital setting  1c) outpatient discharge information	Complete summaries + <ul style="list-style-type: none"> <li>• Named social worker</li> <li>• Details of handover</li> <li>• Exception report if discharged to place other than where admitted from</li> <li>• Medication change explanations</li> <li>• Follow up responsibilities</li> <li>• Complications</li> <li>• Relevant investigation</li> </ul> Majority of summaries to be sent electronically.  <ul style="list-style-type: none"> <li>• Increase in numbers of patients going home on their agreed date (NHS Institute for Innovation Productive Ward Indicators)</li> <li>• Percentage of discharges that occur by twelve noon</li> <li>• Increased percentage of weekend discharges (not applicable to Mon- Friday wards)</li> </ul> Increase in new out-patients who have a letter sent to their GP and any other relevant primary care clinician within five days of the first outpatient appointment summarising: <ul style="list-style-type: none"> <li>• the ongoing care plan</li> </ul>



## Specialised Contract CQUINS

Goal	Parts	Details
<b>Specialised</b>		
<b>Adult BMT</b> Incremental increase in 1 year survival for individual provider		Improvement in 1 year survival rate of patients who have received transplant
<b>Haemophilia</b> Reduce patients BMIs to within the recommended BMI index	1a)  1b)	Collection of BMI figures to identify any patients whose weight leads to an increased BMI  Audit of reduction in BMI following support to reduce weight , to improve diet, encourage appropriate exercise and generally to promote a healthy life-style
<b>HIV</b> Support patients to self manage their HIV Ensure HIV therapy is optimised  Prevent new HIV infections and prevent positive people from becoming unwell  Increase the role of primary care in the care of HIV patients	1 2a) 2b) 2c) 3a) 3b) 3c) 4	Patients involved in decisions about their care and supported to self manage Patients with no resistance on NNRTI therapy Patients failing therapy re-suppressed within 6 months All patients with a CD4 <200 on therapy HIV patients with positive STI results accessing health advisor support Patient with key clinical indicators attending the trust to be tested for HIV Enhance partner notification of newly diagnosed to promote testing Communication with GPs about the care of HIV patients
<b>PICU</b> Reduce delays in discharge for children admitted to a PICU consortium funded bed		To reduce the number of PICU Consortium OBDs associated with LOS above 14 days



<p><b>NICU</b></p> <p>2 Year outcome assessment of all babies admitted to a neonatal unit below 30 weeks gestational age. (DH target N0v 2009)</p> <p>Ensure babies and families have access to appropriate developmental support and on going care packages</p>	<p>1a)</p> <p>1b)</p> <p>2</p>	<p>Access for all babies &lt;30 weeks gestational age at birth to two year developmental outcome monitoring MDT appointments</p> <p>Clear measureable understanding of impact on development of prematurity</p> <p>Details tbc</p>
<p><b>Neuro-Rehab</b></p> <p>Improve responsiveness to personal needs of patients</p> <p>Optimise access times and patient/staff ratio</p> <p>Reduce typical length of stay to up to a max. of 6 months</p> <p>Improve links with primary care</p> <p>Maximise patient safety and assure continuity of care</p>	<p>1a)</p> <p>1b)</p> <p>2a)</p> <p>2b)</p> <p>3a)</p> <p>3b)</p>	<p>Complaints and compliments about the service</p> <p>Rapid transfer times (time to tbc) for patients originally affected by venous thromboembolism</p> <p>Each patient's care plan to be driven by measurable result-oriented outcomes.</p> <p>Review and discharge report to be copied to the GP if patient on GP's long term conditions register (and community rehabilitation teams if further local therapy or psychology input is required).</p> <p>Units will report unit closures within 6 hours</p> <p>Discharge report to include the measured change in patient's key rehabilitation scores on discharge relative to scores on admission.</p>